STANDARD FORM FOR

EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY

State's Number For:	File- Carrier: Employer:
Carrier's File No.	

(The spaces above not to be filled in by Employer)

If Employer's First Report of Injury did not show that the injured had returned to work, an Employer's Supplemental Report of Injury should be completed and filed immediately after the return to work of the employee; or at the end of days.
In the event of the death of the employee, this report should be filed immediately.

1. Name of Employer .....
2. Office address: No. and St ..... City or Town ..... State .....
3. Injured Employee Social Security No ..... - ..... - .....
4. Name of Injured (in full) ..... (First Name) ..... (Middle Name) ..... (Last Name)
5. Present address: No. and St ..... City or Town ..... State ..... Zip Code .....
6. Date of Injury ..... 19/20 ..... Day of week ..... Hour of day ..... A.M. ..... P.M.
7. Date disability began ..... 19/20 ..... A.M. ..... P.M. .....
8. Has injured returned to work? ..... If so, date and hour ..... A.M. ..... P.M.
9. Is injured person earning same wages as before injury? ..... If not, explain .....
10. If disability has not terminated, state probable date of termination of disability .....
11. Has injured died? ..... If so, date of death ..... AM ..... P.M.
12. Additional information:

Date of this report ..... Agency name .....

Signed by ..... Official Title .....

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